

a disadvantage in their current environment.

Much more research by teams of family practitioners and basic scientists is needed throughout the life span to identify the events or circumstances that contribute to the lifelong "normal slowing", so that we may furnish the aged with better reserves to cope with stress and trauma. For example, maybe if our illuminated political leaders enacted legislation to compel hamburger and wiener outlets to add a substantial amount of bone meal to their recipes our teenagers of today would have fewer fractures due to osteoporosis in the future.

**Colin Anderson, MD**  
Department of Pathology  
University of Western Ontario  
London, Ont.

## Olympic mascots: a breath of fresh air

**H**idy and Howdy are large man-made bears who dance, ski and attend various events as part of the promotion of the 1988 Winter Olympics, to be held in Calgary. They work indoors and outdoors and are continuously active. The high-school students who animate the bears frequently feel ill and breathless, and some have fainted.

The costumes consist of a voluminous coverall of artificial fur, a large undergarment of plastic foam and a large headpiece lined with plastic foam that has an internal volume of about 20 L, has an aperture at the top (about 15 cm in diameter), covered with a thin piece of muslin, and sits snugly on the shoulders. The operator's mouth and nose are opposite the bear's mouth, a channel about 10 cm in diameter and 15 cm long that is open to the outside and covered with a light screen.

One of the students was exercised in costume on a treadmill (Fig. 1) in the Foothills Provincial General Hospital pulmonary laboratory at an ambient temperature of 23°C. A mass spectrograph sampled air just in front of the mouth, and a thermistor monitored the temperature inside the headpiece. While the student was walking at a speed of 4 km/h on the level the inspired air inside the costume had an oxygen concentration of 17% (normally 21%) and a carbon dioxide concentration of 3.2% (normally 0.03%). The temperature inside quickly rose to 34°C and remained constant thereafter.

The gas concentrations are best explained by assuming that the headpiece constitutes a large dead space. Given the combination of marked hypoxia and hypercapnia and the high temperature within the headpiece it is not surprising that the occupants

were extremely uncomfortable, breathless and faint.

A small fan driven by a portable battery was installed in the hat on top of the headpiece to force a stream of air down across the face of the operator and out through the mouth of the mask. With this in place, during exercise at the same rate the inspired air in the headpiece had an oxygen concentration of 20.3% and a carbon dioxide concentration of 1%, and the temperature inside the headpiece was 30°C. The operator felt much more comfortable, particularly because of the sensation of a cool draft across his face.

Similar costumes are commonly used in sports and other promotions. The quality of the air breathed will depend on the headpiece's construction, dead space and stream of airflow, but if the conditions are clearly suffocating, installation of a fan should considerably improve the operator's comfort and safety.

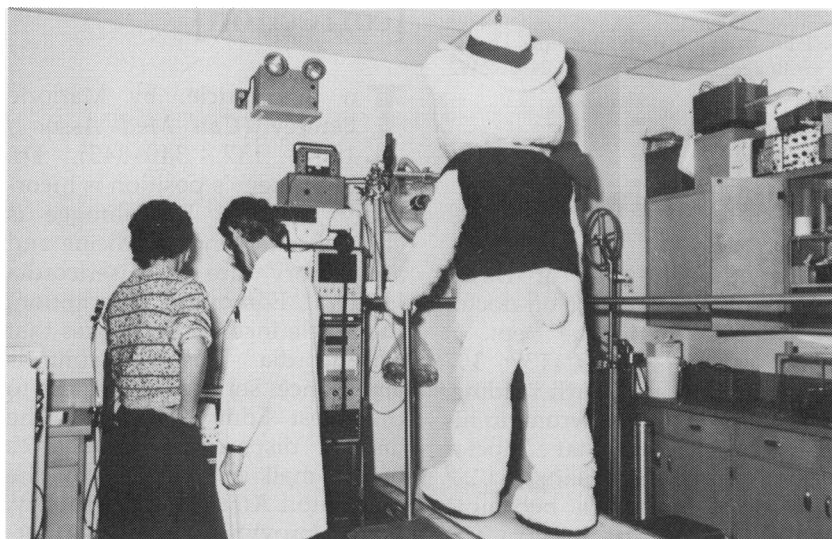
**William A. Whitelaw, MD, FRCPC**  
**John Evans**  
**Karen Rimmer, MD**  
**Bruce Challis, MD, FCFP**  
University of Calgary  
Calgary, Alta.

## New sleep disorder

**W**e would like to bring to the attention of *CMAJ* readers a neurologic disorder that we believe to be a unique clinical entity.

The disorder is characterized by nocturnal somatic hallucinations and abnormal movements. Affected individuals describe lancinating sensations in the legs, flanks or groin, which commence shortly after they retire for the night. These sensations are immediately followed by uncontrolled flinging or kicking of the legs, jactitations, and spontaneous vocalizations, particularly of obscenities.

This sequence of pain and abnormal movements recurs at irregular intervals throughout the night, waking the affected individual and often the spouse as



**Fig. 1 — Howdy being exercised on a treadmill.**

well. Marital discord may result. It is not uncommon for the spouse to have identical symptoms. We have observed a slight familial tendency.

In view of the apparent contagiousness of the disorder, we initially believed the cause to be infectious. However, epidemiologic observations carried out by one of us (M.K.) suggested a highly significant association ( $p = 0.00513$  by Fisher's exact one-tailed, four-legged test) between the symptoms and the presence in the bed of *Felis catus*. We therefore propose that this new sleep disorder be designated "nocturnal myoclawness".

Deborah Black, MD, FRCPC  
Michel Kabay, PhD  
34-4125 Blueridge Cres.  
Montreal, PQ

## Herpes zoster in psychogeriatric practice

**D**iseases characterized in younger people by intense pain may be entirely painless in the elderly, and particularly in psychogeriatric patients. An asymptomatic course often makes diagnosis and treatment difficult.

Herpes zoster, or shingles, is commonly considered to be very painful. I have observed seven patients with typical manifestations of herpes zoster in the last 5 years in a general psychogeriatric population of approximately 230 patients. In four of them the skin lesions culminated in black necroses, which eventually healed, with scarring. Only two complained of itching rather than pain. In all cases the lesions healed within 3 months. All seven patients were being treated with neuroleptic drugs, which have an analgesic effect.<sup>1</sup>

Painless black necroses at nerve endings imply a loss of perception, not just an elevated threshold for pain. Other factors, such as the genetic information carried by the virus and the

strength of the patient's immune system, might also play a role. In schizophrenic patients disordered somatosensory communication has been suggested.<sup>2</sup> Might psychogeriatric patients have pain inhibitors that are absent or not developed in young and mentally normal people? In Alzheimer's disease an altered spectrum of neurotransmitters has been assumed.<sup>3</sup> One of the neurotransmitters, the analgesic effect of which has been confirmed, is serotonin.

The increased threshold for pain in the elderly, and particularly the mentally ill elderly, might be one of the defence mechanisms that allow the continued functioning of old people who would otherwise be crippled by the pain of physiologic degeneration of the body. Should it not be the goal of the geriatrician to reach "asymptomatology" in certain situations (such as Alzheimer's disease) rather than trying to "cure" untreatable, age-dependent degenerative diseases?

Slavoj Hontela, MD  
Department of Psychogeriatrics  
Alberta Hospital Edmonton  
Edmonton, Alta.

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## Doctor bashing

**A**lthough both of David Woods' articles on doctor bashing in the Sept. 1, 1987, issue of *CMAJ* (137: 367 and 433-434) are worth reading, I think Mr. Woods is wrong in his main conclusion, that "doctor bashing is still a popular sport".

Doctor bashing is becoming unpopular, at least locally. The public press, to the best of my

knowledge, didn't publicize the *Financial Post* conference, which Woods' second article characterized as "an exercise in doctor bashing", and Toronto's *Globe and Mail* ignored the conference, while giving front-page coverage on Sept. 12 to the article "Where Manitoba children obtain their cigarettes", by Richard S. Stanwick and colleagues, which appeared in the same issue of *CMAJ* (405-408). There was no doctor bashing at all during the Ontario election campaign, despite the active presence of plenty of well-known doctor haters. I think they sensed that the public had had enough.

The *Financial Post* conference provided necessary freedom of speech to a number of arm-chair experts and vested-interest groups, who can no more survive without their periodic hate message than I can without my 4 pm cup of tea. But "ordinary working people" have clearly had enough of this nonsense, at least for a while. And the public-press journalists seem to know it.

Morton S. Rapp, MD  
39 Elliotwood Ct.  
Willowdale, Ont.

## Mall medicine: "Go past the monkey cages, around the penguin pit" [correction]

**I**n this article, by Marjorie Bentley (*Can Med Assoc J* 1987; 137: 340-343), Dr. David Shragge's position is incorrectly reported: Dr. Shragge is chief of emergency medicine and ambulatory care at Misericordia Hospital, Edmonton. In addition, the article incorrectly implies that Misericordia Hospital controls ambulance services provided to the West Edmonton Mall. The task of dispatching ambulances to the mall is a function of the Edmonton Ambulance Authority, which provides ambulance service to the Edmonton area. — Ed.